The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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STATE PLAN

100 GENERAL DESCRIPTION

110 Introduction -- Attachment 4.19-D covers two types of providers. One is a licensed nursing facility (NF). The other is an intermediate care facility for the mentally retarded (ICF/MR). The cost definition and reporting are similar.

200 DEFINITIONS

Facility -- An institution that furnishes health care to patients.

Provider -- A licensed facility or practitioner who provides services to Medicaid clients.

State -- The State of Utah, Department of Health, Division of Health Care Financing.

Accrual Basis -- That method of accounting wherein revenue is reported in the period when it is earned, regardless of when it is collected and expenses are reported in the period in which they are incurred, regardless of when they are paid.

Plan -- The Medicaid plan prepared by the State of Utah in response to Federal program requirements for Title XIX, ATTACHMENT 4.19-D

HCFA- Pub. 15-1 -- The Medicare Provider Reimbursement Manual published by the U.S. Department of Health and Human Services that defines allowable cost and provides guidance in reporting costs.

Patient Day -- Care of one patient during a day of service. In maintaining statistics, the day of admission is counted as a day of care, but the day of discharge is not counted as a day of patient care.

FCP -- The Facility Cost Profile (FCP) is the cost report filed by providers.

Department -- Utah State Department of Health.

Nursing Facility -- A licensed nursing facility (NF) that provides long term care.

ICF/MR -- A licensed Intermediate Care Facility for the Mentally Retarded that provides long term care.

300 REPORTING AND RECORDS

310 Introduction -- This section of the State addresses five major areas: (1) the accrual basis of accounting; (2) reporting and record keeping requirements; (3) FCP reporting periods; (4) State audits; and (5) federal reporting.

320 Basis for Accounting -- Long-term care providers must submit financial cost reports which are prepared using the accrual basis of accounting in accordance with Generally Accepted Accounting Principles. To properly facilitate auditing and rate calculations, the accounting system must be maintained so that expenditures can be grouped in accounting classifications specified in the facility cost profile (FCP).

330 Reporting and Record Keeping -- The FCP is the basic document used for reporting historical costs, revenue and patient census data. The FCP is sent to providers at least 60 days prior to the due date.

331 Facility Cost Profiles -- The FCP represents the basis for establishing the data base that is used to calculate rate. Therefore, it is essential that the FCPs are filed with accurate and complete data. Non-allowable costs should not be included on the FCP. The provider, and not the auditor authorized by the State, is responsible for the accuracy and appropriateness of the reported information.

332 Reporting -- The FCP is due two months after the end of the reporting period. The provider may request a 15-day extension for extenuating circumstances. The request must be made in writing prior to the due date. The State may grant a 15-day extension only when justified. Failure to file timely FCPs can result in the withholding of payments as described in Section 720.

333 Record Retention -- The State is responsible for keeping the FCPs on file for at least four years following the date of submission. The provider is responsible for maintaining sufficient financial, patient census, statistical, and other records for at least four years following the date of the FCP submission. These records are to be made available to representatives of the State and Federal Governments. The records must be in sufficient detail to substantiate the data reported on the FCP.

340 Reporting Periods -- Generally, the FCP reporting period is for twelve months. However, when there is a new facility or a change in owners or operators, there may be reporting periods of less than twelve months. The reporting period is January 1 through December 31 for NFs and July 1 through June 30 for ICF/MRs. Other reporting periods must be approved by the Department of Health. For exceptions to the designated reporting period, the provider must submit a written request 60 days prior to the first day of the reporting period and the State must issue a written ruling on the request.

350 State Audits -- The State will desk review all FCPs and perform selective audits. In completing the audits, the State, either directly or through contract, will provide for an on-site audit of selected FCPs. The auditor is responsible for verifying the reported reasonable costs. The appropriateness of these costs is to be judged in accordance with the intent of the guidelines established in HCFA-Pub. 15-1, except as otherwise stated in this plan. Audits are conducted in accordance with generally accepted auditing standards. Audits are primarily oriented toward verification of costs reported on the FCP. In determining if the costs are allowable, the auditor examines documentation for expenditures, revenues, patient census and other relevant data.

400 ROUTINE SERVICES

410 Introduction -- This section specifies the services covered in the per diem payment rate and the ancillary services that are billed separately. Because of the difficulty of defining all of the routine services, section 430 specifies those services that are billed directly. Other services are covered by the routine payment rates paid to long-term care providers.

420 Routine Services -- The Medicaid per diem payment rate covers routine services. Such routine services cover the hygienic needs of the patients. Supplies such as tooth paste, shampoo, facial tissue, disposable briefs, and other routine services and supplies specified in 42CFR 483.10 are covered by the Medicaid payment rate and cannot be billed to the patient. The following types of items and services in addition to room, dietary and related services, will be considered to be routine for purposes of Medicaid costs reporting, even though they may be considered ancillary by the facility:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas.

2. Items furnished routinely and relatively uniformly to all patients, such as patient gown, water pitchers, basins, and bedpans.

3. Items stocked at nursing stations or on the floor in gross supply, such as alcohol, applicators, cotton balls, bandaids, suppositories, and tongue depressors.

4. Items used by individual patients which are reusable and expected to be available such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

5. Special dietary supplements used for tube feeding or oral feeding except as provided in Section 430 item 3.

6. Laundry services.

7. Annual dental examinations for ICF/MR patients only.

8. Transportation to meet the medical needs of the patient, except for emergency ambulance.

9. Medical supplies and nonprescription pharmacy items. Supplies include, but are not limited to: syringes, ostomy supplies, irrigation equipment, dressing, catheters, elastic stockings, test tape, IV set up, colostomy bags, etc.

10. Medical consultants.

11. Physical therapy, occupational therapy, speech therapy and audiology examinations for ICF/MR patients only.

12. All other services and supplies that are normally provided by long-term care providers except for the non-routine services specified in Section 430.

430 Non-routine Services -- These services are considered ancillary for Medicaid payment. The costs of these services should not be included on the FCP, but should be billed directly. Such billings are to be made by the supplier and not the long-term care provider. These services are:

1. Physical therapy, speech therapy, and audiology examinations for nursing facility patients only.

2. Oxygen.

3. Prescription drugs (legend drugs) plus antacids, insulin and total nutrition, parenteral or enteral diet given through gastrostomy, jejunostomy, I.V. or stomach tube. In addition, antilipemic agents and hepatic agents or high nitrogen agents are billed by pharmacies directly to Medicaid.

4. Prosthetic devices to include (a) artificial legs, arms and eyes and (b) special braces for the leg, arm, back and neck.

5. Physician services for direct patient care.

6. Laboratory and radiology.

7. Dental services except annual examinations for ICF/MR patients.

8. Emergency ambulance for life threatening or emergency situations.

9. Other professional services for direct patient care, including psychologists, podiatrists, optometrists and audiologists.

10. Eye glasses, dentures, and hearing aids.

11. Special equipment approved by Medicaid that is currently limited to air flotation beds and water flotation beds which are self-contained, thermal regulated and alarm regulated.

431 Definition of Prosthetic Devices

Medicaid defines prosthetic devices to include (1) artificial legs, arms and eyes; (2) special braces for the leg, arm, back and neck and (3) internal body organs. Specifically excluded are urinary collection and retention systems. This definition requires catheters and other devices related to incontinence to be covered by the per diem payment rate.

500 ALLOWABLE COSTS

501 General -- Allowable costs will be determined using the Medicare Provider Reimbursement Manual (HCFA-Pub. 15-1), except as otherwise provided in this Plan.

510 Property Costs -- Property costs are based on the allowable property costs properly included in the rate at March 27, 1981. The property differential will not be affected by sales, leases or other expenditures that occur after March 27, 1981. In conjunction with controls on property cost increases, provisions of HCFA-Pub. 15-1, specifying recapture of depreciation, gains or losses on disposal of assets, and establishing a new basis for depreciation shall not apply to transactions after March 27, 1981.

514 Property Expense -- Property expenses above the "flat rate" component are recognized through the rate differential calculation for NFs based on costs allowed in the March 27, 1981 rate. Similar consideration is given for ICF/MR rates during rate negotiation. For definition of purposes, Real Property Expenses are defined as rent and lease expense, (cost center 02-05 on the Facility Cost Profile [FCP]), depreciation, building and improvements (cost center 02-07 on the FCP) and mortgage interest (cost center 02-10 on the FCP).

520 Owners Compensation -- Owners and their families may claim salary costs as permitted by HCFA-Pub. 15-1.

530 Fringe Benefits -- Benefits are allowed as permitted by HCFA-Pub. 15-1.

540 Alternative Programs -- Some long-term care providers provide specialized programs which are not covered by Medicaid. One such program is day care for older people living in their own homes. Such programs are carved out of the FCP as non-allowable costs. In completing the cost finding for the Medicaid program, two alternatives are available. First, at the election of the provider or when prior approval is not obtained, Medicare cost-finding methodology will apply. Under Medicare cost-finding the specialized program receives its share of overhead allocation on a step-down schedule incorporated in the annual cost report. However, the provider may submit and the State may approve alternative revenue offsets as opposed to cost finding. Advance approval must be obtained prior to the beginning of the reporting period.